

Medicaid Innovation Accelerator Program

Beneficiaries with Complex Needs and High Costs (BCN)

IAP BCN Kick-Off Webinar

October 13, 2015 – 3:00 PM (ET)



Logistics for the Webinar

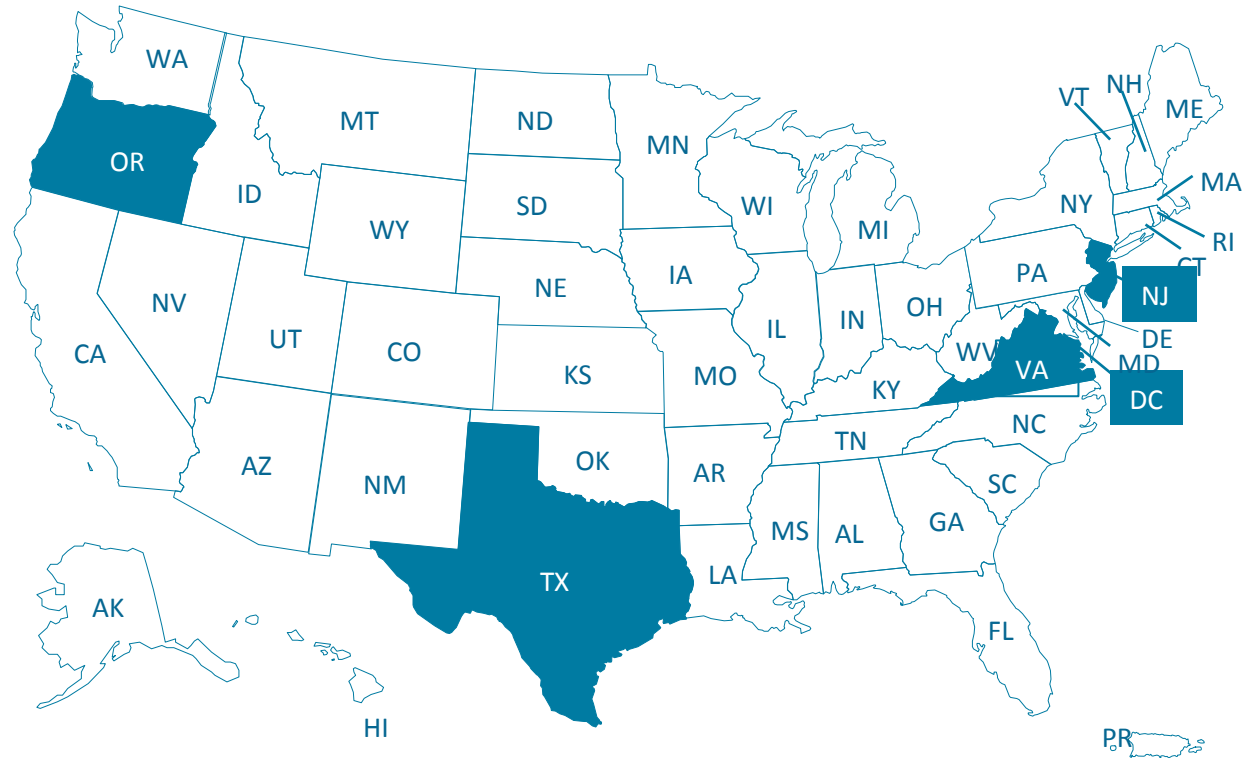
- All lines will be open
- Questions and comments are encouraged
- To minimize background noise, please mute your line when you are not speaking
- Please do not put your line on hold
- To participate in a polling question, exit out of “full screen” mode
- If you wish, the chat feature is available, but will not be visible in full screen mode

Agenda

- Welcome
- Overview of IAP BCN Program
- Introductions
- Understanding State Team Interests
- IAP BCN Schedule
- Next Steps

Welcome State Teams

- District of Columbia
- New Jersey
- Oregon
- Texas
- Virginia



Overview of IAP BCN Program

Medicaid Innovation Accelerator Program (IAP)

- Four year commitment by CMS to build state capacity and accelerate innovation in Medicaid through targeted program support
- A CMMI-funded program that is led by and lives in CMCS
- Opportunity to build states' and our own capacities in key areas
- Matrix staff across CMCS in order to leverage existing knowledge, experiences, and resources

What is IAP's Connection to Delivery System Reform?

- IAP supports states' and HHS delivery system reform efforts:
 - Focus on improving the way providers are incentivized, the way care is delivered, and the way information is distributed
- The end goal for IAP is to increase the number of states moving towards delivery system reform across program priorities

IAP Program Priority Areas: What Has Launched and What Is Underway

Substance Use Disorders	Beneficiaries with High Needs & High Costs	Community Integration – Long-term Services & Supports	Physical Health/ Mental Health Integration
<p>Launched with selected states Jan 2015</p> <p>Ongoing High Intensity Learning Collaborative (HILC)</p> <p>Ongoing Targeted Learning Opportunities (TLO)</p>	<p>Work begins with selected states - October 2015</p>	<p>Information Session scheduled for October 22, 2015</p>	<p>Information Session to be held in early December 2015</p>

Functional Areas: Targeted Technical Support For States

- Functional areas:
 - Data Analytics
 - Quality Measures
 - Rapid Cycle Learning
 - Payment Modeling & Financial Simulations
- States can request targeted technical support unique to their own needs in these areas
- Support in these areas is under design, to be available in 2016

IAP BCN Goals

Over the course of 10 months, state-to-state learning and individualized technical support will be offered to states with the goals of:

1. Identifying ways to enhance states' capacity to use data analytics to better serve the BCN population
2. Developing/refining payment reforms to support BCN programs
3. Facilitating the replication/spread of promising BCN programs

Track A and Track B

- **Track A – Partnering with Providers/Plans (PPP)**
 - Focuses on how state Medicaid agencies can support effective local provider BCN interventions through health information exchange, data analytics, and/or payment reforms to establish/sustain new care models
- **Track B - State Agency Partnerships (SA)**
 - Focuses on state Medicaid agencies forming and/or enhancing partnerships with other state agencies for the purposes of intrastate facilitation of data and analytics capacity, targeting populations and interventions, and/or payment reform

Introductions

CMS IAP Team for Beneficiaries with Complex Needs and High Costs (BCN)

- Program team:
 - Karen Llanos, Director Medicaid IAP
 - Andrew Bindman, University of California San Francisco/IAP
- Additional technical support & expertise provided by:
 - CMCS/IAP Financial Management Group & CMMI Learning and Diffusion Group, and CMCS/IAP Quality measures team
 - Brian Burwell, Truven Health Analytics, IAP Contract Program Director
- Contracted BCN support team:
 - Izanne Leonard-Haak, Health Management Associates
 - Mike Nardone, Health Management Associates

Partnering with Providers and Health Plans - Track A



Texas Team



- **State Lead:**
 - **James A. Cooley**, Policy Specialist, Super-Utilizer Projects Lead
- **Key Team Members:**
 - **Dr. Dan Culica**, works with James
 - **Matt Ferrara**, directs unit that contains super-utilizer work
 - Project workgroup forming
- **Project Partner:**
 - Institute for Child Health Policy, University of Florida, Texas Medicaid-CHIP External Quality Review Organization

Texas' Program and Target Population



- **Goals:**
 - To come up with a replicable method to evaluate promising super-utilizers projects and develop payment models to sustain those that are proven effective. This effort will occur in a state where managed care is the Medicaid model (19 MCOs)
- **Target population:**
 - All Medicaid, but more focus on adults who may have multiple chronic conditions, mental illness, and substance abuse
- **Why this population was selected:**
 - This population is caught between fragmented care silos and sometimes written off. However, there are initiatives that seem to be creating improvements in their care

Texas' Program and Target Population cont'd



- **Main areas of support or interest:**
 - Knowledge transfer with CMS and with other states.
 - Assistance with the development of a solid methodology for evaluating the effectiveness of promising super-utilizer projects
 - Assistance with furthering innovative payment models that enable promising projects to be sustained
 - Assistance with the integration of the bundle of social supports that is often needed to impact medically complex populations. Medicaid is an insurance program, but the care of super-utilizers may require elements that are more social services in nature. This has to be adapted into Medicaid.

New Jersey Team



- **State Lead:**
 - **Julie Cannariato**, point of contact and overall Medicaid policy lead for the project
- **Key Team Members:**
 - **Valerie Harr**, Medicaid Director
 - **Dr. Arturo Brito**, Deputy Commissioner, PHS
 - **SMEs:** Ruby Goyal-Carkeek, Mollie Greene, Meghan Davey, Roxanne Kennedy, Vicki Fresolone, Adam Bucon and Stuart Dubin
- **Project Partners:**
 - Department of Health, Department of Mental Health and Addiction, Department of Children and Families, Department of Law and Safety

New Jersey's Program and Target Population



- **Goals:**
 - Gain the tools and capacities to develop, implement and operationalize effective interventions for a discrete segment of Medicaid beneficiaries with complex needs and high costs
- **Target population:**
 - Young adults with opioid use and dependency issues
- **Why this population was selected:**
 - New Jersey has seen a surge in the number of young adults using opiates and is actively working toward practical cost-effective solutions

New Jersey's Program and Target Population cont'd

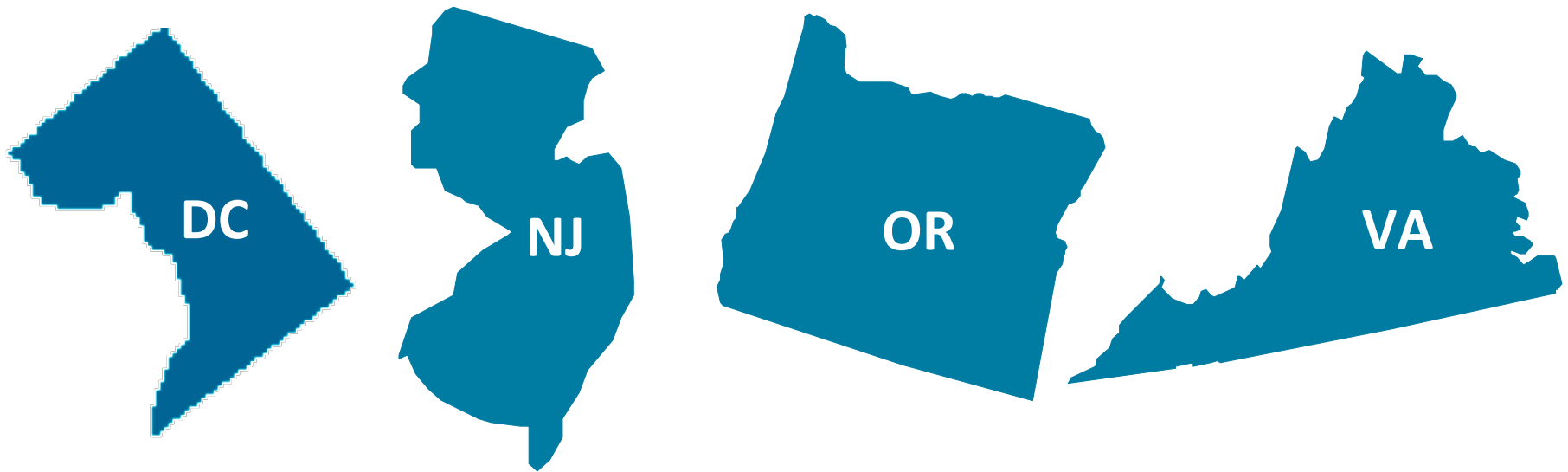


- **Main areas of support or interest:**
 - Cultivate and enhance internal data analytic capabilities
 - Reinforce the importance of sharing and analyzing data among internal and external stakeholders
 - Foster greater collaboration between internal stakeholders and other state-agencies
 - Develop policy guidance informing evidenced-based interventions as part of a continuum of coordinated services
 - Provide an actionable model for future evidence-based interventions to model

Discussion of Provider and Plan Partnerships Track

- Similarities
- Distinctions
- Challenges

State Agency Partnerships - Track B



District of Columbia Team



- **State Lead:**
 - **Claudia Schlosberg**, Senior Deputy Director, Department of Health Care Finance
- **Key Team Members:**
 - **Lisa Fitzpatrick**, Medical Officer; **Shelly Ten Napel**, Director, Health Care Reform and Innovation Administration; **DaShawn Groves**, Lead Project Manager, Health Care Reform and Innovation Administration; **Lisa Truitt**, Director, Health Care Delivery Management Administration; **Cavella Bishop**, Program Manager, Division of Clinician, Pharmacy & Acute Provider Services; **Constance Yancy**, Program Manager, Division of Quality & Health Outcomes; **Charles Thomas**, Policy Advisor, Office of the Deputy Mayor for Health and Human Services
- **Other Project Partners:**
 - Department of Behavioral Health, Department of Human Services

District of Columbia's Program and Target Population



- **Goals:**
 - Several key directives from the Office of the Mayor and other government leaders that seek to
 - Improve the integration of physical and behavioral health care;
 - Improve health outcomes through a scalable care coordination strategy; and
 - Better coordinate health and social services in an effort to end chronic homelessness in the District.
- **Target population:**
 - Health Home for serious and persistent mental illness (SMI)
 - Health Home for chronic conditions
 - Individuals with 2 – 4 chronic conditions, or 1-3 chronic conditions and at risk of another
 - Two risk factors: Chronically homeless; Smoking

District of Columbia's Program and Target Population cont'd



- **Main areas of support or interest:**
 - To better understand our high-cost, high need population
 - To identify and overcome the barriers and challenges of data-sharing
 - To effectively share data throughout the District's Health and Human Service agencies and Medicare
 - To integrate other data sources into Medicaid claims data
 - To identify care delivery models that provide effective linkages between primary care and other health care providers to social services providers
 - To learn how other states reward providers for the coordination of health and social services within payment model

Oregon Team



- **State Lead:**

- **Jennifer Valentine**, MSPH, Operations and Policy Analyst, Dual Eligibles, OHA, IAP Project Facilitator

- **Key Team Members:**

- **Hyunjee Kim, PhD**, Project Lead Researcher, OHSU Center for Health System Effectiveness(CHSE)
- **Christina Charlesworth**, MPH, Project Research Analyst, OHSU, CHSE
- **Jon Collins**, Manager, Health Programs Analysis & Measurement, OHA
- **Stacey DeLong**, Health Systems Data & Research Manager, OHA
- **Christopher Coon**, Data Management Lead Analyst, OHA
- **John McConnell**, OHSU, CHSE Center Director

- **Project Partners:**

- Oregon DHS APD (LTSS)

Oregon's Program and Target Population



- **Goals:**

- We are working to create data tracking and evaluation of full dual eligibles in our Coordinated Care Organizations and Fee-For Service
 1. Examine the effect of Coordinated Care Organization (CCO) implementation on health service use among dual-eligibles.
 2. Examine the effect of CCO implementation on the quality of care among dual-eligibles

- **Target population:**

- All Full Dual Eligibles, FFS and Coordinated Care Enrolled. This will include dual eligibles with mental health and physical health needs, as well as duals using long-term services and supports

- **Why this population was selected:**

- Important Next Step for Oregon to Meet Our Triple Aim Targets, and advance the Coordinated Care Model

Oregon's Program and Target Population cont'd



- **Main areas of support or interest :** This project targets IAP BCN goal 1 to enhance state capacity to use data analytics to better serve the dual eligible BCN population...We also want to build more sophistication in our ability to look at data to inform policy and our partnerships with our Coordinated Care Organizations, D-SNPs and other work with affiliated Medicare Advantage plans to ultimately address additional work in areas 2 and 3.
- **What do you hope to gain for your state from this experience:** The technical assistance and support will enhance our overall statewide capacity to track and monitor outcomes for dual eligibles and further additional policy and program work to impact this BCN population. Specifically we look to gain: assistance with the integration of multiple datasets, database consolidation, creation of consistent interpretation of data fields across different databases, assistance to develop/find solutions for gaps associated with missing or inconsistent data, assistance with programming and complex algorithms that may be required to read and use the data for integration, developing protocols for cleaning and linking data sets.

Virginia Team



- **Name of State Lead:**
 - **Bhaskar Mukherjee**, Director of Analytics
- **Key Team Members:**
 - **Suzanne Gore**, Deputy Director of Administration
 - **Tammy Driscoll**, Senior Programs Advisor
 - **Molly Dean**, Specialist Assistant to the Director
 - **Seon Rockwell**, Senior Programs Advisor
 - **Mel Boynton**, Data Analyst
- **Project Partners:**
 - Department of Behavioral Health and Developmental Disabilities
 - Virginia Department of Health

Virginia's Program and Target Population



- **Goals:**
 - Better leverage data to understand risks, needs, and health outcomes of Medicaid enrollees with complex needs. Leverage the data to enhance continuity of care especially during transitions and improve the overall quality of care for the individuals with complex needs
- **Target population:**
 - Dual eligible enrollees and individuals receiving long term services and supports
- **Why this population was selected:**
 - Care is delivered through a patchwork of fragmented health and social programs that are not necessarily responsive to the individual's needs
 - There is an opportunity to improve our how we pay for services to financially incent high-quality interdisciplinary care in the right setting, accelerate innovation to create value, and control growth in spending.

Virginia's Program and Target Population cont'd



- **Main areas of support or interest:**
 - Utilize risk stratification to identify and coordinate care for individuals with complex needs
 - Explore how data sharing among Agency partners can enhance our understanding of and improve care for the target population
 - Focus on evidenced-based interventions including use of data from a variety of sources across the continuum of care to support care coordination and transitions, and measure the impact of those interventions
 - Explore how we can leverage data analytics to drive payment reform focused on improving treatment outcomes through value-based payments

Discussion of State Agency Partnerships Track

- Similarities
- Distinctions
- Challenges

Understanding State Team Interests

Team-to-Team Discussion:

Type of Data Support Identified

- **Targeting**
- **Determining impactability**
- **Data sharing**
- **Legal challenges to intrastate facilitation of data**
- **Obtaining Medicare data (CMS will discuss available pathways)**

Team-to-Team Discussion:

Other Interests Identified

- **Value based purchasing**
- **Federal authorities**
- **Quality measurement strategy**
- **Medicaid's role in addressing social determinants (e.g. housing, non-medical social needs)**
- **Other**

IAP BCN Schedule

What You Can Expect...



Medicaid Beneficiaries with Complex Needs and High Costs: IAP and State Participation

The Center for Medicaid and CHIP Services (CMCS) is pleased to extend an invitation to your state for participation in the Medicaid Innovation Accelerator Program – Improving Care for Medicaid Beneficiaries with Complex Needs and High Costs (IAP-BCN). As discussed on our introductory call, this document is confirmation of IAP's commitment to supporting your state's BCN program needs and outlines what you can expect as a state participating in the IAP-BCN activity.

	IAP will...	Participating states will...
Timeframe	...provide structured program support to participating states throughout the first 10 months (October 2015 through July 2016). After July 2016, IAP will offer a lighter touch of ongoing program support via conference calls as requested by the state through the end of the 2018.	...participate in the structured portion of the BCN activity (as outlined in this document) from October 2015 through July 2016. States may also be asked to provide periodic updates on their progress as part of the IAP evaluation after the structured period through 2018.
Strategic Planning	...facilitate an initial strategic planning process in which the state, the CMS Rapid Cycle Learning (RCL) team, and the IAP team assigned to assist the state, identify/confirm the key drivers related to its BCN activity using a Driver Diagram tool. The resulting driver diagram will help focus the state's BCN activity and the program assistance IAP will provide, and support a rapid cycle learning process.	...participate in an initial strategic planning process to identify/confirm the overall goals and objectives of the state's BCN activity, the proposed timeline for major milestones and the key participants. The key tool used in this process will be a driver diagram (see an introduction to Driver Diagrams in the attachment labeled "What's Your Theory?").
State-Specific Action Plan	...provide 3:1 support to states in developing (or refining) and maintaining their state-specific BCN action plans. IAP will make available a planning template for states that do not already have an existing action plan. This template is structured to enable states to develop action steps which address the major drivers identified as part of the strategic planning process discussed above.	...share their existing work plan or develop a state-specific BCN action plan. Revisions to the state-specific plan may be made at appropriate times, and the objectives identified may be modified or refined by the state as new data findings emerge or changes surface as part of the rapid cycle learning process. States will also be asked to self-assess their progress toward their identified objectives at quarterly intervals and the conclusion of the 10 months structured program.
Individualized Programmatic Support	...provide individualized 3:1 program and technical support throughout the first 10 months of the BCN activity. As requested by the state, this individualized program support will be available at a lighter touch via conference calls after the initial 10 month period up through the end of 2018.	...provide ongoing feedback related to the types and methods of support your state needs from IAP.
On-site Visit	...make the IAP team available for an on-site visit to meet with the state's BCN team at least once during the state's involvement in the BCN activity. The timing and focus of this on-site visit will be determined in conjunction with the state.	...work with IAP to identify when an on-site visit to the state by the IAP team would be most useful (e.g., on site visit could focus on: refining the state's BCN planning process; providing a more intensive exploration of the state's BCN environment, challenges and needs; assisting in refining the states' data analytics processes; or supporting other programmatic needs identified by the state which can best be achieved through in-person engagement).
In-Person Workshop	...offer an in-person workshop at which IAP will provide experts based on the participating BCN states' expressed areas of interest and facilitate topic specific	...take part in an in-person workshop to be held in the Baltimore, Maryland area. This workshop will be structured around the specific needs identified by

IAP BCN Schedule

Event	Target Date
BCN Kick-off Webinar	October 13, 2015
Monthly Virtual 1:1 Individualized Support	October 2015 – July 2016
Strategic Planning: Model for Improvement and Driver Diagram Development	November 2015
Sharing State-Specific Action Plan	December 2015
Monthly Virtual State-to-State Workshops	December 2015 – July 2016
In-Person Workshop	March 2016 (tentative)
On Site Support (as requested)	TBD
Ongoing Program Support (as requested)	Through 2018
Reporting of Common Metric	Through 2018

Discussion: Draft Approach to Monthly State-to-State Workshops

Month	Tentative Workshop Schedule*	Location
October	BCN Kick-Off Webinar	Virtual
November	Improvement Theory/Rapid Cycle Learning	Virtual
December	Targeting Methodologies/Determining Impactability/ Monitoring	Virtual
January	Critical Questions, Data Sets & Payment Authorities (Check in with States about Pace and Content)	Virtual
February	Payment Reform Strategies & Necessary Data Supports	Virtual
March	In-person Workshop: Data Analytics, Intrastate Facilitation of Data, Payment Reform Strategies, Federal Authorities, Scaling & Sustainability	Baltimore
April	Deeper Dive: BCN Data Sets (Intra-state Facilitation of Data)	Virtual
May	Deeper Dive: Intrastate Facilitation of Data/Data Governance	Virtual
June	Effective BCN Program Monitoring & Evaluation	Virtual
July	TBD (based on states' interest)	Virtual

Proposed Monthly Virtual State-to-State Workshops Webinar Date/Time

Monday at 2:00 PM EST

3rd Week of every month

Questions or Comments?



Next Steps

- The next webinar will be held on November 16th at 2pm on Improvement Theory/Rapid Cycle Learning
- Your team lead will be contacted by your state coach for an introductory call

Poll #1: Experience with the Model for Improvement/Improvement Theory

- Don't know/No experience
- Have been exposed
- Limited use
- Widely applied (already an integral part of our state's program development)

Contact Information

Izanne Leonard-Haak

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ileonardhaak@healthmanagement.com

We Look Forward to Working With You to...

- 1. Identify ways to enhance states' capacity to use data analytics to better serve the BCN population**
- 2. Develop/refine payment reforms to support BCN programs**
- 3. Facilitate the replication/spread of promising BCN programs**